Department of Health
Office of Emergency Medical Services & Trauma System

PERSONAL STATUS CHANGES APPLICATION

IDENTIFYING INFORMATION:

Department of Health Registry Number | Telephone Number | Date of Birth (mm/dd/yyyy)

Last Name | First Name | M.I. | Previous Name (if different)

Address, City, State, Zip Code

E-mail Address

CERTIFICATION LEVEL: (Please select one.)

☐ First Responder ☐ EMT ☐ IV Tech ☐ Airway Tech ☐ IV/Airway Tech ☐ ILS Tech ☐ ILS/Airway Tech ☐ Paramedic

PERSONAL STATUS CHANGES: (Please select all that apply.)

☐ Add Agency ☐ Change Agency ☐ Change Address ☐ Change Name

EMS SUPERVISOR STATEMENT (required when changing and/or adding agencies):

"I attest this applicant will provide care with our EMS agency."

Agency Name and License Number

EMS Supervisor's Original Signature Date

Employment Status with this Agency: (Please select one) ☐ Paid **OR** ☐ Volunteer

Will this be your Primary Agency?: (Please select one) ☐ Yes **OR** ☐ No

COUNTY MEDICAL PROGRAM DIRECTOR (MPD) STATEMENT (required when changing and/or adding counties, and when a provider returns to active agency affiliation):

☐ ***"I Recommend*** ☐ ***"I Do Not Recommend***

state certification of this applicant in my county. Applicants recommended for certification have a copy of my protocols.

County MPD's Original Signature Date

APPLICANT STATEMENT:

"I hereby attest and declare that the information provided on this application is true and correct, and that any fraudulent entry may be considered sufficient cause for rejection or subsequent revocation of my certification. I further attest that I have received a copy of the MPD's protocols for my level of certification."

NOTE: This application is valid for a period of six months from the date the applicant signs the form.

Applicant's Original Signature Date

VOID IF ALTERED OR PRINTED ON COLORED PAPER

Department of Health, *Office of EMS & Trauma System,* PO Box 47853, Olympia WA 98504-7853

(Revised 5/06) Supersedes All Previous Forms

RESET FORM PRINT FORM